

# PUBLIC HEALTH PROGRAMS AND PRACTICES

## Organ Transplant Success Rate Continues High, HRSA Report Shows

Nearly 94 percent of patients with kidney transplants—the most common transplant procedure—were alive 1 year after surgery, according to a national report released by the Health Resources and Services Administration (HRSA) of the Public Health Service. The rate is almost a full percentage point greater than for a similar study reported in 1991.

"The 1994 Report of Center-Specific Graft and Patient Survival Rates" shows patient survival after 1 year for kidney transplants at 93.8 percent; pancreas, 90.5 percent; heart, 82.4 percent; liver, 76.7 percent; lung, 68.4 percent, and heart-lung, 57 percent.

"Lung transplant patients showed the greatest increase in survival, with an improvement of almost 15 percent over the previous study period," said HRSA Administrator Ciro V. Sumaya, MD, MPMTM.

Despite this success rate—and some 38,000 people on the national waiting list to receive organs—there were only 4,800 donors in the country during 1994. This represents only one-third of the estimated potential donors (if all donors were identified and if all families consented to donation).

The report was compiled by the United Network for Organ Sharing of Richmond, VA, under contract to HRSA's Division of Transplantation in the Bureau of Health Resources Development. The information is intended to assist patients, their families, and physicians when considering transplant options, and to help transplant centers evaluate their outcomes compared with other centers.

This is the second time national organ-specific and transplant-center-specific data have been collected. An earlier report covering data from 1987 to 1989 also showed a high transplant success rate, including a 92.9-percent 1-year survival rate for kidney transplants.

The nine-volume report is the only national documentation of the success of transplant technology on a hospital-by-hospital basis. The report analyzes data on 60,100 transplant procedures performed on 57,457 patients in 640

transplant programs at 261 hospitals during the period October 1, 1987, to December 31, 1991.

Division of Organ Transplantation Director Judith B. Braslow explained that data on survival rates for both the organ (graft survival) and the organ recipient (patient survival) are averaged nationally. Data from each center are compared against these national averages, taking into account the patient mix at each center, including the medical diagnosis, the age, sex, and race of the patient, the type of donor (living donor or cadaver), the number of transplant procedures performed at each center, and advances in transplant technology.

This comparison results in the expected survival rate specific to each transplant center. When patient characteristics are taken into consideration, actual survival rates at most transplant centers are similar to their expected rates. Less than 10 percent of the programs had actual rates below their expected rates.

*"The 1994 Report of Center-Specific Graft and Patient Survival Rates" consists of nine volumes, two with kidney transplant data and one each with data on heart, liver, pancreas, heart-lung, and lung transplants. There is also an executive summary and a user's guide.*

*Telephone numbers and addresses of transplant centers or organ procurement groups can be obtained by calling the United Network for Organ Sharing at 804-330-8500.*

*A copy of the entire report, a single volume, information on a maximum of 10 transplant programs, or the report's executive summary, or user's guide can be obtained by calling the toll-free numbers 1-800-243-6667 or 1-800-243-donor.*

## Vaccination Compensation Criteria Revised

The Health Resources and Services Administration (HRSA) of the Public Health Service has announced changes in some of the criteria used by the Federal Government to make childhood vaccine injury awards.

The major revisions made after considering findings by the Institute of Medicine (IOM) add one condition as vaccine-related and remove others. The major changes follow:

- Chronic arthritis, if it arises within 42 days of the rubella (German measles) vaccine's administration, is added to those conditions which may be compensated for.
- Residual seizure disorder and shock-collapse or hypotonic-hyporesponsive episode after the pertussis (whooping cough) vaccine will no longer be given a legal presumption that they are caused by the vaccine.

Serious reactions to vaccines are rare but can be costly to an affected person's family. Congress created the National Vaccine Injury Compensation Program in 1986 to provide a no-fault system for the care of those who develop a problem following vaccination without their having to resort to expensive, and less certain, litigation. To qualify for compensation, parents can either demonstrate that an injury was caused by a vaccine or simply show that an injury listed on the Vaccine Injury Table occurred.

If the condition is included in the table, parents can apply for compensation without having to prove cause and effect. Removal of a condition from the Vaccine Injury Table does not bar parents from being compensated. Parents may receive compensation if they demonstrate a cause and effect relationship.

When the initial Vaccine Injury Table was established, Congress suggested that IOM, which is part of the National Academy of Sciences, should review the literature on adverse events associated with the pertussis and rubella vaccines. Congress mandated that the Secretary of Health and Human Services then update the Vaccine Injury Table based on current medical information. This is the first set of changes to the table.

Petitions for compensation under the Program are filed with the U.S. Court of Federal Claims. Recommendations on whether claims meet the requirements for compensation are made to the court by HRSA based in part on the table.

The revisions were proposed in

1992 based on findings of the July 1991 IOM report, "Adverse Effects of Pertussis and Rubella Vaccines."

HRSA held up the final regulation until it could also review a followup study by IOM called "DPT Vaccine and Chronic Nervous System Dysfunction: A New Analysis," published in 1994.

HRSA also reviewed recommendations by the Public Health Service Task Force on the Vaccine Injury Compensation Program and two other advisory bodies—the National Vaccine Advisory Committee and the Advisory Commission on Childhood Vaccines.

The revisions to the table became effective March 10, 1995. Claims filed on or after the effective date will be adjudicated using the new table.

*Additional information can be obtained from Shelly Burgess, HRSA, tel. 301-443-3376.*

## **Stanford Center Handbook Designed to Help Health Advocates Effect Change**

The Stanford Center for Research in Disease Prevention of the Stanford University School of Medicine has published "Public Health Advocacy: Creating Community Change to Improve Health," a handbook for advocates.

The book is primarily intended for those who are new to advocacy—people who have found a need to change conditions that are relevant to the health of their communities but are uncertain how to proceed. The handbook is designed to give them confidence, whether they intend to bring about changes in laws and policies, draw attention to shortages of health facilities, confront corporate polluters of air and water, or fight city hall.

The 162-page book takes the new advocate systematically through the steps needed for success, starting with the formation of a group, and proceeding through analysis of the issues, strategic planning, use of the media, and evaluation. It also provides worksheets, examples of successful advocacy, and resources for further study and guidance.

The book was written by five experts who combine academic knowledge of the subject with practical experience in the field. Coordinating the team was

David G. Altman, PhD, Associate Professor at Bowman Gray Schools of Medicine, Wake Forest University. The other authors were Professor Stephen B. Fawcett, PhD, University of Kansas, Fabricio E. Balcazar, PhD, University of Illinois, Thomas Seekins, PhD, University of Montana, and John Q. Young, PhD, Stanford University.

The handbook is a component in the series of health promotion materials produced by the Stanford Center for Research in Disease Prevention, under a grant from the Henry J. Kaiser Family Foundation.

*"Public Health Advocacy: Creating Community Change to Improve Health," can be obtained for \$24, plus \$4.50 shipping and handling, from the Stanford Center for Research in Disease Prevention Distribution Center, 1000 Welch Rd., Palo Alto, CA 94304-1825; telephone (415) 723-0003.*

## **HHS Issues Biennial Report on U.S. Prevention**

The Department of Health and Human Services (HHS) has issued "Prevention '93/'94," the fifth biennial report on the prevention-related activities of the Federal Government.

This listing of the comprehensive prevention programs of HHS includes those of its component parts—the Administration on Aging, the Administration for Children and Families, the Health Care Financing Administration, and the nine agencies of the Public Health Service.

In addition, other agencies of the Federal Government report prevention programs such as the activities of the Environmental Protection Agency; the Women, Infants, and Children Program of the Department of Agriculture; and the Occupational Safety and Health Program of the Department of Labor.

"Healthy People 2000: National Health Promotion and Disease Prevention Objectives" serves as the framework for "Prevention '93/'94." The national initiative set forth in "Healthy People 2000" established three overarching goals—increase healthy life-span, reduce health disparities, and achieve access to preventive services—to be achieved by the year 2000.

The nation's prevention agenda for improvements in public health rests on three categories of preventive action:

1. Health promotion, encompassing both healthy behaviors and risk reduction;
2. Health protection, addressing screening as well as the physical and social environment; and
3. Preventive services, including immunizations, counseling, and other clinical preventive services.

Within these three categories of prevention are 21 priority areas that provide the substance of health promotion and disease prevention strategies. A 22nd priority area addresses improvements in surveillance and data systems necessary for tracking progress of the Healthy People 2000 objectives.

Chapter 1 of "Prevention '93/'94" highlights model prevention programs for minorities. These programs were nominated by the State Healthy People 2000 action contacts and the minority health directors of agencies of the Public Health Service.

Chapter 2 provides a snapshot of the health status of all Americans. Trends in mortality rates and the causes of deaths are examined. New tables have been added since "Prevention '91/'92" to illustrate the differences among race and ethnic groups in selected causes of death. Life expectancy by race and sex, and years of healthy life by race and ethnicity are provided.

Chapter 3 describes the prevention activities of HHS and other Federal departments and agencies.

Chapter 4 displays the expenditures for prevention by HHS. Organized by Healthy People 2000 priority areas, this inventory tracks fiscal year 1992 actual spending and estimated 1993 funding by agency in the Public Health Service and from the Administration for Children and Families and the Health Care Financing Administration. A summary table shows block grant resources.

*"Prevention '93/'94," order No. 017-001-00522-3, is available from the U.S. Government Printing Office for \$17.*

## **New Foundation Initiative to Track Changing Health Care System**

The Robert Wood Johnson Foundation has launched a multi-million-dollar ini-

tiative to track and report on changes in the U.S. health care system and how they affect Americans' health.

The foundation plans to spend at least \$2.5 million on the initiative until July 1996, with significantly more funding likely to follow over the next decade.

"When Federal health care reform died, the pace of change accelerated in the private market—HMOs, managed care plans, and the like—and in the 50 States," said Steven A. Schroeder, MD, foundation president. "The health system all of us thought we knew is, frankly, gone. And the new system is evolving before our eyes.

"We feel an obligation to see how these changes are helping or hurting Americans and to use what we learn to encourage a better system," said Schroeder, referring to the foundation, the nation's largest private grantmaker in the health care field.

Centerpiece of the foundation's initiative is a new research center, which will be an affiliate of Mathematica Policy Research, Inc. (MPR), to be called the Center for Studying Health System Change. The new research organization will be headed by health economist Paul B. Ginsburg.

Since 1986, Ginsburg has been Executive Director of the Physician Payment Review Commission, a body established by Congress to give advice on Medicare and Medicaid payments to physicians as well as many other health care reform issues.

The center will be housed in MPR's Washington, DC, office.

Under its larger tracking initiative, the Johnson Foundation will make a significant commitment to ensuring that timely, useful information on health system changes—from the center and other sources—is made available to government and private policy makers and the public.

## **Leprosy to be Eliminated Before 2000, WHO Says**

The world is well on the way to eliminating leprosy as a public health problem before the end of this century, according to the World Health Organization (WHO) whose global action plan envisages the identification and cure of about 5 million cases in the next 5 years.

Leprosy is caused by a bacillus,

*Mycobacterium leprae*, that reproduces very slowly and mainly affects the skin, nerves, and mucous membrane. If untreated, there can be progressive and permanent damage to skin, limbs, and eyes. But the visible symptoms may not show themselves for 10, 15 or even 20 years.

By that time, paucibacillary cases (having few bacteria in their bodies) may have "only" 1 million bacteria; multibacillary cases may have more than 7 billion bacilli in just 1 gram of skin tissue.

At the start of this century, leprosy was universally regarded as incurable. The first breakthrough came in the 1940s with the development of the drug dapsone. It cured the disease, but only if the patient regularly took the proper dose over many years. Moreover, *M. leprae* started to develop resistance to dapsone, and it seemed as if the world's only known safe anti-leprosy drug was about to become useless.

In 1981, a WHO study group was able to recommend treatment with a "cocktail" of three drugs—dapsone, rifampicin, and clofazimine—that effectively prevented the bacillus from becoming resistant to any of the three. Called multi-drug therapy or MDT, this is the weapon that now seems certain to stop the disease in its tracks.

MDT has proved remarkably effective, reasonably cheap, and highly acceptable to all patients. The treatment will last 6 months for persons with paucibacillary cases and 24 months for those with multibacillary cases. At the end of those periods, the cure is complete.

Provided all the countries where leprosy is endemic maintain their casefinding and MDT treatment activities, and provided donors worldwide keep up and even increase the flow of resources—financial and human—to maintain the momentum, leprosy can be eliminated as a public health problem by the year 2000.

WHO considers leprosy no longer a public health problem when the number of cases in a given country falls below 1 per 10,000 population. Globally, there has already been an astonishing 56-percent decrease in the estimated number of cases in the world, from 5.5 million in 1991 to about 2.2 million in 1994.

A total of 79 countries are technically endemic for leprosy today. Only 25 of these are rated as the "most

endemic" countries, and they contribute 93 percent of all cases. They are Bangladesh, Brazil, Cambodia, Chad, Colombia, Cote d'Ivoire, Egypt, Ethiopia, Guinea, India, Indonesia, Iran, Madagascar, Mali, Mexico, Mozambique, Myanmar, Nepal, Niger, Nigeria, Philippines, Sudan, Thailand, Viet Nam, and Zaire.

By the end of 1994, an estimated 6.5 million patients had been cured with MDT and the global prevalence had been reduced by about 69 percent. MDT has also prevented the development of physical disabilities in from 1 to 2 million people. The global coverage of MDT currently stands at nearly 55 percent, although the cumulative MDT coverage—which takes into account the number of people cured with MDT in the past—had reached 92 percent by 1994.

A person may be completely cured, but if there is severe damage to the limbs, that damage cannot always be put right. So there will be a long-term problem of rehabilitation and treatment for people disabled by the disease. In many parts of the world, they may also have a struggle to reintegrate themselves into their communities. Ancient fears of leprosy die hard.

WHO, through its Action Program for the Elimination of Leprosy, oversees the quest for resources, monitors and evaluates the activities in each endemic country, and generally coordinates the progress towards elimination worldwide. It also promotes the building up of national capabilities to carry out leprosy elimination programs and encourages research for still more effective drugs as component parts of MDT.

## **Public Health Services in Zaire Overstretched**

Despite the fact that hundreds of thousands of lives have been saved through international response to the Rwanda crisis, the local public health services in the Nord Kivu region of Zaire are now virtually collapsing under the additional burden of providing health care to more than half a million Rwandan refugees, according to the reports of the World Health Organization (WHO) team in Goma, Zaire.

The Nord Kivu region (population 2,586,000) which includes Ruthsuru, Goma, and Kirotshe districts, shelters more than half of all Rwandan refu-

gees in Zaire. The city of Goma, with a Zairian population of 138,000, has in addition thousands of refugees living outside assisted camp structures, thus contributing to the overall density of population.

The local public health services are stretched to the breaking point, trying to satisfy the health needs of the local population as well as providing health care to the refugee community.

WHO experts on the spot now believe that the local health system is on the verge of collapse. Essential drugs supplies are extremely erratic. Due to the unfavorable economic situation, the local health workers are not being paid their wages and salaries regularly. As a result, many of them work now for nongovernmental emergency relief organizations (NGOs) at the camps where they can be guaranteed regular payment. Public health services are free of charge for the refugees but not for the local population.

With the arrival of the Rwandan refugees, the United Nations agencies and various other institutions, including NGOs, have injected resources—health personnel, equipment, drugs—into a system designed to support the refugees. But this system has practically no connection with the previously existing local health system for the Zairian population. (See *"PHS Mission to Goma, Zaire" in the January-February 1995 issue of Public Health Reports, p. 95.*)

The existence of the two systems with mutually exclusive target populations creates an ever widening gap between the health system for the refugees and that for the Zairians in terms of access and availability of services. This is not an exclusively Zairian situation. The same developments are observed in Burundi and Tanzania, the other two countries sheltering large numbers of Rwandan refugees.

There are clear indications that the overall health situation in refugee camps is improving. Mortality rates declined from 8 per 10,000 population per day in August 1994 to 1.2 per 10,000 per day in December 1994. Constant efforts are needed, however, to keep diarrheal diseases, malaria, measles, and other infectious diseases under control.

Comparative analysis of morbidity and mortality in children younger than age 5 points to a greater disease incidence among Zairian children. For

diarrheal diseases and malaria, the incidence amongst the children younger than 5 in the Zairian population around Goma is about twice as high as among the same population group in the Rwandan refugee camps. As for the adult population, the situation is practically the same.

## **NIOSH Report Catalogues Work-Related Lung Disease**

The National Institute for Occupational Safety and Health's (NIOSH) Work-Related Lung Disease (WoRLD) Surveillance Report, 1994 summarizes surveillance data for occupational lung diseases such as asbestosis, coal workers' pneumoconiosis, silicosis, byssinosis, hypersensitivity pneumonitis, and occupational asthma.

The report contains case-based and rate-based surveillance data, crude and age-adjusted mortality rates, geographic distribution of occupational lung diseases, and proportionate mortality ratios. The majority of the data are for the period 1968–90, although the period covered varies for some of the data sources.

Surveillance information in the report derives from various sources—the Coal Workers' X-ray Surveillance Program, the National Occupational Health Survey of Mining, and the Sentinel Event Notification System for Occupational Risks. Other data sources are publications, reports, and analysis of data provided by the National Center for Health Statistics, Department of Labor, Social Security Administration, Mine Safety and Health Administration, Bureau of Mines, and Association of Occupational and Environmental Clinics (AOEC).

The report is divided into 11 major sections. The first 10 present data on specific occupational lung diseases, summarizing mortality and morbidity data, and other available information such as occupational exposures or numbers of workers at risk. The remaining section provides data from the AOEC database. Each section contains figures and tables. The appendices describe each major data source and methods used for computation of specific statistics.

The information on the magnitudes, trends, and geographic distributions of occupational lung diseases in the United States, 1968–90 is important and useful for establishing priorities of

programs, for investigation and intervention, and for tracking progress toward elimination of preventable occupational lung diseases.

It is a reference for health administrators, physicians, health educators, professional researchers, employers, and workers.

*Copies of "The 1994 Work-Related Lung Disease Surveillance Report" may be obtained from Surveillance Section, Epidemiological Investigations Branch, DRDS, NIOSH, 1095 Willowdale Rd., Morgantown, WV 26505-2888; telephone (304) 285-6115; FAX (304) 285-6111.*

## **NIDR's New Oral Cancer Guide Does Double Duty**

The National Institute of Dental Research (NIDR) has issued an unusual new publication, "Detecting Oral Cancer: a Guide for Dentists."

The guide, which includes information about the prevalence, signs and symptoms, and survival rates of oral cancer, measures 6.5 inches square closed and opens out to a 20 × 32-inch poster that illustrates how to perform a head and neck examination.

An evaluation card is enclosed in the poster so professionals in the dental community can help NIDR evaluate and improve its materials.

*Quantities of the oral cancer poster can be obtained from Oral Cancer Screening Posters, National Institute of Dental Research, Building 31, Room 2C35, 31 Center Dr. MSC 2290 Bethesda, MD 20892-2290; tel. 301-496-4261.*